Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BERNIE L MCCASKILL

Respondent Name
TRUMBULL INSURANCE CO

MFDR Tracking Number
M4-14-0205-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in receipt of your explanation of benefits for a Maximum Medical Improvement and/or Impairment Rating examination, for which we are requesting reconsideration because the bill was processed incorrectly."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 01, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2013	CPT Code 99455-V3-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - QA – The amount adjusted is due to bundling or unbundling of services

Issues

1. Is CPT Code 99455-V3-WP supported?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

   (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

   (A) the examination;

   (B) consultation with the injured employee;

   (C) review of the records and films;

   (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

   (3) The following applies for billing and reimbursement of an MMI evaluation.

   (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

   (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

   (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

   (4) The following applies for billing and reimbursement of an IR evaluation.

   (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

   (II) upper extremities and hands; and,

   (III) lower extremities (including feet).

   (ii) The MAR for musculoskeletal body areas shall be as follows.

   (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

   (II) If full physical evaluation, with range of motion, is performed:

   (-a-) $300 for the first musculoskeletal body area; and

   (-b-) $150 for each additional musculoskeletal body area.

   CPT Code 99455-V3-WP is not supported. Review of submitted documentation finds report from the examining doctor which states maximum medical improvement raised, however impairment rating portion for body area rated is not supported in accordance with 28 Texas Administrative 134.204 (4)(C)(I)(II).

   The reimbursement for maximum medical improvement examination is $119.22.

2. The respondent issued payment in the amount of $119.22. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/27/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.